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RECENT SHIFTS IN RURAL MEDICAL FACILITIES

SUMMARY

A smaller proportion of rural than urban physicians has gone into the armed forces. But rural medical facilities, generally poorer than in urban areas, have been reduced even more than the urban facilities. Before the war, many town doctors were available for some rural practice, whereas now more, or all, of their time is taken up with office visits and town calls.

Relatively fewer rural than urban doctors have gone into the armed forces because rural doctors are generally older than urban doctors. They are older primarily because most of the medical graduates in recent years have located in the larger urban communities where opportunities for remunerative practice have been greater and where hospital and clinical facilities are most available.

With the coming of the war and the consequent movement of many of the younger doctors into the armed forces, the requests for medical service in local communities have increased in response to rising incomes and elective surgery incident to physical requirements for employment in war industries and entrance into the armed forces. Many people have come to feel that maintenance of good health is a patriotic responsibility, and with larger incomes they expect more services from the doctor. As the requests for medical service increased and the number of doctors decreased, the remaining doctors have come to do more office work, to make fewer home calls, and to expect the general public to cooperate in conserving the doctor's time and strength.

Neither the farm people nor the doctors in the 34 counties observed have yet worked out any effective plans to make more doctors available to the rural people, or to make rural medical services more effective through the better use of the doctors now available. In only a few counties have rural leaders and doctors given any thought to the establishment of weekly or monthly clinics convenient to farm people, to doctors making multiple calls and maintaining scheduled office hours in "doctorless towns," to the extension of membership in hospital care associations to more rural people, or to the organization of appropriate first aid and home nursing courses for the rural families with low incomes and low educational status.

SHIFTS IN RURAL MEDICAL FACILITIES*

On December 16, 1942, at hearings of the subcommittee on manpower of the Senate Committee on Education and Labor, Dr. F. D. Mott, Chief Medical Officer of the Farm Security Administration, stated that, "Even before the war, there were far too few physicians in rural America. The trend toward the loss of rural physicians has been evident for 40 years. Of the 21 States which between 1923 and 1938 showed a loss of about 20 percent in the ratio of physicians to population, 18 were rural States.

"Thirty-five years ago," Dr. Mott's statement continued, "one-half of young medical graduates located in places of less than 5,000 population. By 1923, less than one-quarter and by 1931 less than one-fifth of graduates located in communities under 5,000 - although such areas include 48 percent of our whole population. This has resulted in situations such as existed in Tennessee even before the war, when 77 percent of the rural physicians were over 50 years of age." Referring to movement of physicians into the armed forces, Dr. Mott said, "When State quotas of physicians for the armed forces were finally set by the Procurement and Assignment Service, it was the predominantly rural States which oversubscribed their quotas. As of September 30, 1942, of the 26 rural States, 24 had exceeded their quotas, 11 of them having furnished over 150 percent of their quotas."

The data presented in this report will show how a general situation such as this applies to representative local communities.

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*The data presented here were secured from 34 widely scattered counties by the field staff of the Division of Farm Population and Rural Welfare.

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Almost without exception, when the war came, the average age of rural doctors was higher than that of urban doctors. In several of the counties, practically all of the doctors in the open country and in towns of 2,500 or less were 50 years or older.

With distances greater and family incomes generally lower, a physician in the rural areas could hardly hope for an income commensurate with that of his professional associates in the city. Generally speaking, the smaller towns and open country have been attractive to the best equipped medical graduates only when they wanted to live in the country so much that they were willing to forego the greater monetary returns of practice in the more compact urban communities. The other side of the picture has been that sometimes a doctor who could not earn enough to pay the high office rents and living costs in the city has moved to a small town or the open country, set up an office in his home, and supervised the operation of a farm to supplement his income. Medical education, in emphasizing the use of hospitals, laboratories, and clinics, has trained the doctors to locate in the communities where these facilities are available.

With the younger doctors congregated in the urban centers, relatively fewer have gone into the armed forces from the rural areas of these counties than from the urban communities in them. The loss of comparatively fewer rural doctors, however, does not mean that rural dwellers have the same medical facilities they had before the war, or that the rural people now have even relatively as adequate medical facilities as they did before the war.*

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*The relative losses of trained nurses and dentists, too, have been smaller from rural than urban communities. But as with medical service, the rural dwellers are the more handicapped, for but few nurses and dentists lived in the open country and smaller towns, and some of these were relatively inactive because of age or non-professional activities.

The pre-war differences between availability of urban and rural medical services remain, and in most counties have become more marked. For with many of the rural doctors too elderly to carry on a full practice, the rural people in many communities had come to depend upon the younger town doctors a great deal, especially for emergency and night calls. Quite naturally, since a disproportionate number of the doctors who went into the armed forces were the younger doctors from the larger towns and cities, those who still remain are busier than ever with town calls and office visits. The result is that even though most rural areas have lost relatively few doctors, the available medical services to rural people have been greatly reduced.

Medical Facilities Decrease

Here are the detailed facts from a few representative counties about the movement of doctors into the armed forces, and the age of the rural doctors available:

By late October 1942, 16 doctors - one-third of the total - had left Pittsylvania County, Virginia (93,000 population). Fifteen of these went from Danville and suburbs (population 38,000), 1 from the remainder of the county (population 55,000). But even after the departure of the urban doctors, the city had 24 physicians, or 1 to every 1,550 people, whereas in the remainder of the county there were but 8 physicians, 1 to every 7,000 people - and 7 of these 8 were over 60 years of age.

In Merced County, California, (population 47,000) where 20 out of 42 doctors have already gone into the armed forces, the rural areas have had their proportion of younger doctors, but have suffered the greater losses to the armed forces. Of the 22 physicians now available in the county,

only 16 are carrying on full-time practice. Seven of those are under 40 years of age, and according to local reports, most or all of them are likely to be called into the armed forces within the next few months. In the outlying sections of the county, that is, in the smaller towns farthest from Merced, the county-seat and largest town, the loss of physicians has been greatest. The small town of Atwater, for example, has lost both of its physicians and is now dependent upon a new physician over 50 years of age who recently moved there. The town of Dos Palos has lost 3 out of its 4 physicians, and the fourth, under 30 years of age, is expecting to be called soon. Gustine has lost all 3 of its physicians, and Livingston has lost 2 out of 4, with the remaining two available for limited practice only because of advanced age. Imperial County, California, (population 59,750) had 28 physicians in 1941, 10 less by the end of 1942. Of the 18 doctors now available, 15 are 45 years or over, and 3 are doing limited practice.

The detailed facts are generally similar for Oneida County, New York (population 203,000), Hampshire County, Massachusetts (population 70,000), and other counties with large urban centers in them.

The situation in the more rural counties varied from the loss of no physicians to the loss of nearly all of them. McCulloch County, Texas, (population 13,200) has 8 doctors, has lost none to the armed forces. The 2 who live in the open country are 65 and 69 years of age. Of the 6 in the county-seat town (population 5,000), only 1 is under 50. From Johnson County, Texas, (population 30,384) 6 doctors went into the armed forces and 1 to a defense plant, leaving 15 active physicians, 8 of whom are over 68 years of age and all but 1 over 60.

Seward County, Nebraska, (population 14,200) [illegible] is 36, the next youngest 59, and the other 4 over 65. From Robin County, Georgia, (population 7,800) 1 of the 4 physicians recently entered the armed forces. Fisher County, Texas, (population 12,900) has lost no one of its 3 physicians, but 2 of them are of military age and expect to be called soon. Latimer County, Oklahoma, (population 12,390) has lost 1 doctor to the armed forces; the 2 who remain are over 65. Desha County, Arkansas, (population 27,200) has 13 doctors, 10 of whom are over 55 years. Claiborne County, Mississippi, (population 12,800) now has only 1 physician available for general practice. He is 37 years old, has been called up for armed forces, but [illegible] deferred for 6 months in response to the request of the people of the county.*

Losses of physicians occurred in practically all counties except where all of the physicians were elderly, as was the case of the two in Haskell County, Kansas, or where the departures of the younger physicians were [illegible] delayed in response to requests of local citizens.

As the physicians, and nurses, have gone into the armed forces, many hospitals and county public health departments are operating with reduced staffs. One small hospital has already been closed in Seward County, Nebraska, and another one will be closed in Fisher County, Texas, if two of the three physicians of the county go into the armed forces as now expected. The public health program has been discontinued in Haskell County, Kansas, because of the loss of the nurse.

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*Information compiled from 727 counties scattered throughout 42 states by the FSA in September 1942, shows that 8.5 percent of the rural doctors had gone into the armed forces as compared with 12.2 percent for the U.S. as a whole. Commenting on this fact, the FSA report (made by Margaret I. Stein) said: "That the rural rate is somewhat less may be due in part to the fact that there are in those areas fewer physicians under 35 years of age than in the cities."

Over against these losses of doctors and nurses and hospital facilities, some expansions of health facilities have occurred. A small public maternity hospital has been opened in Tabun County, Georgia; a new public health unit in Ward County, North Dakota; a new hospital for Kaiser shipyard workers in Clark County, Washington; and [illegible] ly for seasonal agricultural workers, in Imperial County, California.

Requests for Medical Service Increase

The decrease of medical facilities through the movement of physicians into the armed forces and the reduction of hospital staffs occurred at a time when requests for medical services from the general public were on the increase. Rising incomes have caused many families to desire more use of doctors and hospitals than ever.

The increased use of hospitals was sometimes caused by physicians who felt that they could thus take care of their larger number of patients by placing them in the hospital earlier and perhaps leaving them there longer. This early proved impracticable, even impossible, because with rising income there were greater demands being made upon the hospitals than before. A larger number of obstetric cases were going to the hospitals. There has also been a marked increase of elective surgery in many of the [illegible]. Able to take care of their hospital bills, additional numbers of people were ready to have a chronic appendix removed, and other surgical work. The fact that defense plants give examinations before offering employment increased elective surgery. A goodly number of people have had hernia operations, and other elective surgical work done to qualify them

for defense employment. There have been instances of draftees, who were turned down because of minor defects, going to the hospitals for operations.

Many people have come to feel that it is their duty, because of the shortage of manpower, to maintain good health so they can work effectively on farms, in industry, or at their profession. Many people feel that needless poor health now is an evidence of lack of patriotism.

In some areas where defense workers have come in great numbers, local people feel that they need to take particular precautions lest they contract some disease from the newcomers. The location of defense industries in a community raises the question of whose responsibility it is to maintain the health of defense workers. Is that the job of the public health service of the local community? Or does the Federal Government have an obligation to see to it that an additional number of doctors is brought in to meet the increased needs? In areas quite distant from defense industries, some people expressed fear that some of their doctors would be conscripted and moved off into these defense areas.

Farmers everywhere expressed the belief that a great number of doctors ought to go into the armed forces so they will be available for the soldiers, sailors, and marines, wherever they may go. Of all the farmers interviewed in the 34 counties, only 1 expressed the feeling that too many doctors had gone with the armed forces. In every other instance, it seemed to be assumed that the loss of doctors to the local community was an inevitable consequence of war.

No Plans Worked Out for Rural People

Broadly speaking, farm people do not yet feel the need for any particular plan to compensate for the loss of doctors to the armed forces

they seem to feel that so long as they or their neighbors can get any gas and tires and so long as trains and buses make their regular schedules, they will be able to get to the doctor's office. And in case of severe illness, they will be able to find a doctor who will come to their house, day or night. In some places, where cars are fewest, farmers with automobiles are somewhat uneasy because of their neighbors' assumptions about getting to the doctor when necessary this winter.

Little or no thought, it seems, is being given to the possibility that doctors might arrange to be at community centers on certain hours each week, or to make multiple calls, or that scheduled weekly transportation to clinics or doctors' offices be worked out through the use of school buses or trucks. There has been some increase of doctors arranging for a few hours a week in doctorless towns, but on the whole this has not reached any proportions which could be called a trend. Medical services have been somewhat replenished in some communities by the return to practice of elderly

Keenly aware of the increased demands made upon them, the physicians are generally insisting that they not be called except when actually needed for medical service. "The time has come," one doctor said, "when the hypochondriacs will have to suffer alone, when the strength and time of the doctors are needed for real medical work." Some doctors feel a campaign should be launched to teach the general public when to call a doctor, and when not to, also that people go to the doctor's office during regular office hours, and not call him at night except in emergencies.

The movement of doctors into the armed forces and the increase of local medical service because of increased incomes and other war conditions

have often had the effect of increasing the practice of other practitioners, osteopaths, chiropractors, and herb doctors. In the Northeast, where there are a number of European refugee doctors, it was pointed out that they are having increased work to do and that their status is being made more secure. Physicians almost everywhere are doing more work than usual.

Druggists in most rural areas report an increase in the sale of proprietary medicine, not so much because of the decrease of doctors as because of the increase in general purchasing power. In a few places, there have been phenomenal increases recently in the sale of vitamin tablets.

First Aid and Home Nursing Courses

It is significant that at the time when doctors have been moving into the armed forces, the Red Cross and the agricultural agencies have sponsored first aid courses, home nursing courses, and nutrition classes. Most of these courses have been given to prepare local people to take care of themselves in times of air raids and other war conditions. The farm women who have had these courses feel some confidence in their own ability to take care of minor accidents and illnesses without a doctor.

It should be observed, however, that the membership of most of the classes has included only the members of the economically more secure families who have the most status in the community, and who are most accustomed to medical service. In the 34 counties observed, no effective organization has been worked out to get the mothers and daughters of the poorer families into first aid courses, home nursing, or nutrition classes. Obviously, the need for such information is great among the families accustomed

o the least medical service. The greatest need for these services obtains in communities where there are tremendous numbers of migratory farm workers, share croppers, and other low-income farm families.

In many counties, the Extension Service's Community Leadership program might readily help the Red Cross arrange first aid and home nursing courses for the lower-income groups. County Boards of Health, County Nutrition Committees, and other agencies could also assist in getting these classes organized, and in arranging for qualified teachers. Negro home demonstration agents in southern counties could give effective aid, as could also the Jeans' Supervisors of rural Negro schools, and the Negro school [illegible]

One county health officer, however, insisted that first aid, home nursing courses, and nutrition classes can be effective only with people who have the language facility to understand the subject matter. He stated that there is little use to organize classes except among the upper-income rural groups, that the more poorly educated families in the rural areas can get little aid from these courses. It was his opinion that the only way to reach the poorer people was through the high schools, and he hoped first aid and home nursing courses would soon be made a regular part of the high school curriculum. He said that these courses, though seldom directly reaching members of the very poorest families, would reach many more families than any other approach in that the youngsters who got the training would be more willing than would be their elders to apply their skills to members of the lowest social and economic groups. The county physician emphasized that so long as the first aid, home nursing, and nutrition classes are limited as now to the upper-status women, they will not make very much difference

in the health situation among the people who are in the greatest need of medical service.

The Unschooled Can Be Taught

There is abundant evidence that these low-income and least educated rural dwellers are far from unteachable. The FSA program, for example, has proven that they can be taught all sorts of things. Perhaps not out of books, perhaps not in classes conducted in a room, but there are other ways of teaching them, singly and in groups. The FSA program has demonstrated that many families with little or no formal education can be taught to care for a cow and grow more meat, raise chickens in spring or summer and have eggs in midwinter, maintain a good year-round garden, can vegetables and meats with a pressure cooker, make their children's clothes, and so on.

A considerable number of the poorer rural families in the counties observed are also learning how to use the medical services that the FSA and the local doctors have provided for them through monthly prepayment plans.* There were at first, of course, instances when the clients called the doctor too much, or didn't call him enough, or had the doctor come to their house rather than to go to the expense of taking a slightly ailing member to the doctor's office. All sorts of irregularities have occurred, and many of them have already been corrected. It is clear that low-income rural families can learn, and it is unduly pessimistic to assume that people with low economic and low educational status cannot profit by first aid, home nursing, and nutrition courses. Perhaps what is needed is more adequate adult

*Many of the FSA Health Associations are functioning as before any doctors went into the armed forces; others have been modified; a few have been discontinued.

educational techniques. One illiterate FSA mother put it this way: "When you see a thing done, you don't have to know how to read to do it." Perhaps most of the teaching for this group ought to be done on a practical demonstration basis, with the people themselves taking an active part in the demonstrations.